DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

Corrected OFFICIAL FILE COPY

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 1 — 0 1

2. STATE: Texas

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2001

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Section 1902(aa) Social Security Act

7. FEDERAL BUDGET IMPACT: See Attached
a. FFY 2001 $ -0-
b. FFY 2002 $ -0-

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
See Attachment

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
See Attachment

10. SUBJECT OF AMENDMENT: Amendment No. 586 This amendment revises the payment methodology to Rural Health Clinics (RHCs) and Federally Qualified Health Clinics (FQHCs).

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Sent to Governor's Office this date. Comments, i any, will be forwarded upon receipt.

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Linda K. Wertz

13. TYPED NAME:
Linda K. Wertz

14. TITLE:
State Medicaid Director

15. DATE SUBMITTED:
~~September 20, 2001~~ March 29, 2001

16. RETURN TO:

Linda K. Wertz
State Medicaid Director
Health and Human Services Commission
Post Office Box 13247
Austin, Texas 78711

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: ~~March 30, 2001~~ ~~September 20, 2001~~

18. DATE APPROVED: ~~November 13, 2001~~

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
January 1, 2001

20. SIGNATURE OF REGIONAL OFFICIAL:
Calvin G. Cline

21. TYPED NAME:
Calvin G. Cline

22. TITLE:
Associate Regional Administrator
Division of Medicaid and State Operations

23. REMARKS:
* Pen & ink changes per State.

FORM HCFA-179 (07-92)

Instructions on Back

Revised

Attachment to HCFA-179 for
Transmittal No. 01-01, Amendment No. 586

Number of the Plan Section or Attachment	Number of the Superseded Plan Section or Attachment
Attachment 4.19-B	Attachment 4.19-B
Page 5	Page 5 (TN78-14
Page 5a	New
Page 5b	New
Page 5c	New
Page 5d	New
Page 5e	New
Page 5f	New
Page 5g	New
Page 5h	New
Page 5i	New
Page 5j	New
Page 5k	New
Page 5l	New
Page 24	Page 24 (TN90-24)
Page 24a	Page 24a (TN90-24)
Page 24b	Page 24b (TN90-24)
Page 24c	New
Page 24d	New
Page 24e	New
Page 24f	New
Page 24g	New
Page 24h	New
Page 24i	New
Page 24j	New
Page 24k	New
Page 24l	New
Page 24m	New
Page 24n	New

13. Rural Health Clinics (RHC):

For services provided by an RHC and other ambulatory services that are covered under the plan and furnished by an RHC in accordance with Section 4231 of the State Medicaid Manual (HCFA Pub. 45-4).

For RHC facilities employing the Prospective Payment System (PPS) Methodology.

(a) In accordance with Section 1902 (aa) of the Social Security Act as amended by the Benefits Improvement and Protection Act (BIPA) of 2000, effective for the RHC's fiscal year which includes dates of service occurring January 1, 2001, and after, RHC's will be reimbursed a PPS per visit rate for Medicaid covered services. There will no longer be a cost settlement for RHCs for dates of services on or after January 1, 2001.

(b) The PPS per visit rate for both hospital-based and freestanding RHCs will be calculated based on one hundred percent (100%) of the average of the RHC's reasonable costs for providing Medicaid covered services as determined from audited cost reports for the RHC's 1999 and 2000 fiscal years. The PPS per visit rates will be calculated by adding the total audited reimbursable costs as determined from the 1999 and 2000 cost reports and dividing by the total audited visits for these same two periods.

(c) For hospital-based RHCs, an interim PPS per visit rate for each RHC will be calculated based upon the encounter rate from the latest finalized cost report settlement, adjusted as provided for in Subsection (h). For freestanding RHCs, the interim PPS per visit rate for each RHC will be based upon the per visit rate in the Medicaid payment system as of December 31, 2000, adjusted as provided for in Subsection (h). When the commission has determined a final PPS rate, interim payments will be reconciled back to January 1, 2001.

(d) Reasonable costs, as used in setting the interim PPS rate, the PPS rate or any subsequent effective rate, is defined as those costs which are allowable under Medicare Cost Principles as outlined in 42 CFR part 413. The cost limits that were in place on December 31, 2000, shall be maintained in determining reasonable costs. Reasonable costs shall not include unallowable costs.

(e) Unallowable costs are expenses which are incurred by an RHC, and which are not directly or indirectly related to the provision of covered services according to applicable laws, rules, and standards. An RHC may expend funds on unallowable cost items, but those costs must not be included in the cost report/survey, and they are not used in calculating a rate determination. Unallowable costs include, but are not necessarily limited to, the following:

STATE Texas
DATE REC'D 03-30-01
DATE APPV'D 11-13-01
DATE EFF. 01-01-01
HCFA 179 TX-01-01

A

(1) Compensation in the form of salaries, benefits, or any form of compensation given to individuals who are not directly or indirectly related to the provision of covered services;

(2) Personal expenses not directly related to the provision of covered services;

(3) Management fees or indirect costs that are not derived from the actual cost of materials, supplies, or services necessary for the delivery of covered services, unless the operational need and cost effectiveness can be demonstrated;

(4) Advertising expenses other than those for advertising in the telephone directory yellow pages, for employee or contract labor recruitment, and for meeting any statutory or regulatory requirement;

(5) Business expenses not directly related to the provision of covered services. For example, expenses associated with the sale or purchase of a business or expenses associated with the sale or purchase of investments;

(6) Political contributions;

(7) Depreciation and amortization of unallowable costs, including amounts in excess of those resulting from the straight line depreciation method; capitalized lease expenses, less any maintenance expenses, in excess of the actual lease payment; and goodwill or any excess above the actual value of the physical assets at the time of purchase. Regarding the purchase of a business, the depreciable basis will be the lesser of the historical but not depreciated cost to the previous owner, or the purchase price of the assets. Any depreciation in excess of this amount is unallowable;

(8) Trade discounts and allowances of all types, including returns, allowances, and refunds, received on purchases of goods or services. These are reductions of costs to which they relate and thus, by reference, are unallowable;

(9) Donated facilities, materials, supplies, and services including the values assigned to the services of unpaid workers and volunteers whether directly or indirectly related to covered services, except as permitted in 42 CFR Part 413;

(10) Dues to all types of political and social organizations, and to professional associations whose functions and purpose are not reasonably related to the development and operation of patient care facilities and programs, or the rendering of patient care services;

(11) Entertainment expenses except those incurred for entertainment provided to the staff of the RHC as an employee benefit. An example of entertainment expenses is lunch during the provision of continuing medical education on-site;

(12) Board of Director's fees including travel costs and provided meals for these directors;

(13) Fines and penalties for violations of regulations, statutes, and ordinances of all types;

(14) Fund raising and promotional expenses except as noted in paragraph (4) of this subsection;

(15) Interest expenses on loans pertaining to unallowable items, such as investments. Also the interest expense on that portion of interest paid which is reduced or offset by interest income;

(16) Insurance premiums pertaining to items of unallowable cost;

(17) Any accrued expenses that are not a legal obligation of the provider or are not clearly enumerated as to dollar amount;

(18) Mileage expense exceeding the current reimbursement rate set by the federal government for its employee travel;

(19) Cost for goods or services which are purchased from a related party and which exceed the original cost to the related party;

(20) Out-of-state travel expenses not related to the provision of covered services, except out-of-state travel expenses for training courses which increase the quality of medical care and/or the operating efficiency of the RHC;

(21) Over-funding contributions to self-insurance funds which do not represent payments based on current liabilities;

(f) A visit is a face-to-face encounter between an RHC patient and a physician, physician assistant, advanced nurse practitioner, certified nurse-midwife, visiting nurse, or clinical nurse practitioner. Encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit, except where one of the following conditions exist:

SUPERSEDES: NONE - NEW PAGE

STATE Texas
DATE REC'D 03-30-01
DATE APPV'D 11-13-01
DATE EFF 01-01-01
HCFA 179 TX-01-01

A

(1) After the first encounter, the patient suffers illness or injury requiring additional diagnosis or treatment; or

(2) The RHC patient has a medical visit and an "other" health visit.

(g) A visit is a face-to-face encounter between an RHC patient and a physician, physician assistant, advanced nurse practitioner, certified nurse mid-wife, visiting nurse, or clinical nurse practitioner. An "other" health visit includes, but is not limited to, a face-to-face encounter between an RHC patient and a clinical social worker.

(h) Effective for each RHC's fiscal year which includes dates of services occurring on or after October 1, 2001, subsequent increases in an RHC's PPS per visit rate or the effective rate shall be the rate of change in the Medicare Economic Index (MEI) for Primary Care.

(i) The effective rate is the rate paid to the RHC for the current fiscal year. The effective rate equals the base rate plus the MEI for each of the RHC's fiscal years since the setting of its PPS rate. The effective rate shall be calculated at the start of each RHC's fiscal year and shall be applied prospectively for that fiscal year.

(j) An adjustment shall be made to the effective rate if change is due to a change in scope. An RHC or the commission may request an adjustment of the effective rate equal to one hundred percent (100%) of reasonable costs by the filing of a cost report and the necessary documentation to support a claim that the RHC has undergone a change in scope. A cost report, filed to request an adjustment in the effective rate, may be filed at any time during an RHC's fiscal year but no later than five (5) calendar months after the end of the RHC's fiscal year. All requests for adjustment in the RHC's effective rate must include at least 6 months of financial data. Any effective rate adjustment granted as a result of such a filing must be completed within sixty (60) days of receipt of a workable cost report and documentation supporting the RHC's claim that it has undergone a change in scope. Within sixty (60) days of submitting a workable cost report, HHSC or its designee shall make a determination regarding a new effective rate. The new effective rate shall become effective the first day of the month immediately following its determination. All subsequent increases shall be calculated using the adjusted effective rate.

(k) Any request to adjust an effective rate must be accompanied by documentation showing that the RHC has had a change in scope.

(l) A change in scope of services provided by an RHC includes the addition or deletion of a service or a change in the magnitude, intensity or character of services

STATE Texas
DATE REC'D 03-30-01
DATE APPV'D 11-13-01
DATE EFF 01-01-01
HCFA 179 TX-01-01

A

currently offered by an RHC or one of the RHC's sites. A change in scope includes:

(1) Increase in service intensity attributable to changes in the types of patients served, including but not limited to, HIV/AIDS, homeless, elderly, migrant, other chronic diseases or special populations;

(2) Any changes in services or provider mix provided by an RHC or one of its sites;

(3) Changes in operating costs which have occurred during the fiscal year and which are attributable to capital expenditures including new service facilities or regulatory compliance;

(4) Changes in operating costs attributable to changes in technology or medical practices at the center;

(5) Indirect medical education adjustments and a direct graduate medical education payment that reflects the costs of providing teaching services to interns and residents; or

(6) Any changes in scope approved by the Health Resources and Service Administration (HRSA).

(m) A workable cost report includes the following:

(1) For a hospital-based RHC, complete HCFA Form 2552 and HCFA Form 339 with Certification by an Officer or Administrator including:

(A) M-1 (Analysis of provider-based RHC costs).

(B) M-2 (Allocation of overhead to RHC services).

(C) M-3 (Calculation of reimbursement settlement for RHC services).

(D) M-5 (Analysis of payments to hospital-based RHC services rendered to program beneficiaries).

(E) S-8 (Statistical Data/Information Purposes).

(F) RHC net expenses for allocation of costs for services rendered on or after January 1, 1998, reported on the hospital's worksheet A, column 7

STATE Texas
DATE REC'D 03-30-01
DATE APPV'D 11-13-01
DATE EFF 01-01-01

A

trace properly to the RHC's total facility costs on line 32, column 7 on M-1 worksheet.

(G) Hospital's overhead worksheet expenses allocated to each of the hospital-based RHC cost centers on worksheet B, Part I (column 27 minus column 0) trace properly to line 15, column 5 on M-2 worksheet for each hospital-based RHC..

(2) For a freestanding RHC, a complete HCFA 222 Form and HCFA 339 form with Certification by an Officer of Administrator.

(n) Once the base rate for an RHC has been calculated, the RHC shall be paid its effective rate without the need to file a cost report. Except as specified in subsection (o), a cost report shall only be required if the RHC is seeking to adjust its effective rate.

(o) New RHCs shall file a projected cost report within 90 days of their designation to establish an initial payment rate. The cost report will contain the RHC's reasonable costs anticipated to be incurred during the RHC's initial fiscal year. The RHC shall file a cost report within five (5) months of the end of the RHC's initial fiscal year. The cost settlement must be completed within six (6) months of receipt of a cost report. The cost per visit rate established by the cost settlement process shall be the base rate. Any subsequent increases shall be calculated as provided herein. A new RHC location established by an existing RHC participating in the Medicaid program shall receive the same effective rate as the RHC establishing the new location. An RHC establishing a new location may request an adjustment to its effective rate as provided herein if its costs have increased as a result of establishing a new location.

(p) In the event that the total amount paid to an RHC by a managed care organization is less than the amount that the RHC would receive under PPS, the state will reimburse the difference on a quarterly basis. The state's quarterly supplemental payment obligation will be determined by subtracting the baseline payment under the contract for services being provided from the effective rate without regard to the effects of financial incentives that are linked to utilization outcomes, reductions in patient cost or bonuses.

(q) Submission of Audited Medicare Cost Reports. An RHC shall submit a copy of its audited Medicare cost report to the state within 15 days of receipt.

SUPERSEDES: NONE - NEW PAGE

STATE	Texas
DATE REC'D	03-30-01
DATE APPV'D	11-13-01
DATE EFF	01-01-01
HCFA 179	TX-01-01

A

13. Rural Health Clinics (RHC):

For services provided by an RHC and other ambulatory services that are covered under the plan and furnished by an RHC in accordance with Section 4231 of the State Medicaid Manual (HCFA Pub. 45-4).

RHCs may be reimbursed using an alternative methodology. Written and signed agreements will be obtained from all RHC providers agreeing to the alternative methodology.

(a) In accordance with Section 1902 (aa) of the Social Security Act as amended by the Benefits Improvement and Protection Act (BIPA) of 2000, effective for the RHC's fiscal year which includes dates of service occurring January 1, 2001, and after, RHC's will be reimbursed a PPS per visit rate for Medicaid covered services. There will no longer be a cost settlement for RHCs for dates of services on or after January 1, 2001.

(b) The PPS per visit rate for both hospital-based and freestanding RHCs will be calculated based on one hundred percent (100%) of the average of the RHC's reasonable costs for providing Medicaid covered services as determined from audited cost reports for the RHC's 1999 and 2000 fiscal years. The PPS per visit rates will be calculated by adding the total audited reimbursable costs as determined from the 1999 and 2000 cost reports and dividing by the total audited visits for these same two periods. The per visit rate using this alternative methodology will provide reimbursement equal to or greater than what would have occurred under PPS.

(c) For hospital-based RHCs, an interim PPS per visit rate for each RHC will be calculated based upon the encounter rate from the latest cost report settlement, adjusted as provided for in Subsection (h). For freestanding RHCs, the interim PPS per visit rate for each RHC will be based upon the per visit rate in the Medicaid payment system as of December 31, 2000, adjusted as provided for in Subsection (h). When the commission has determined a final PPS rate, interim payments will be reconciled back to January 1, 2001. Adjustments will be made only if the interim payments are less than what would have occurred under PPS.

(d) Reasonable costs, as used in setting the interim PPS rate, the PPS rate or any subsequent effective rate, is defined as those costs which are allowable under Medicare Cost Principles as outlined in 42 CFR part 413. The cost limits that were in place on December 31, 2000, shall be maintained in determining reasonable costs. Reasonable costs shall not include unallowable costs.

SUPERSEDES: NONE - NEW PAGE

STATE Texas
DATE REC'D 03-30-01
DATE APP'D 11-13-01
DATE EFF 01-01-01
HCFA 179 TX-01-01

A

(e) Unallowable costs are expenses which are incurred by an RHC, and which are not directly or indirectly related to the provision of covered services according to applicable laws, rules, and standards. An RHC may expend funds on unallowable cost items, but those costs must not be included in the cost report/survey, and they are not used in calculating a rate determination. Unallowable costs include, but are not necessarily limited to, the following:

(1) Compensation in the form of salaries, benefits, or any form of compensation given to individuals who are not directly or indirectly related to the provision of covered services;

(2) Personal expenses not directly related to the provision of covered services;

(3) Management fees or indirect costs that are not derived from the actual cost of materials, supplies, or services necessary for the delivery of covered services, unless the operational need and cost effectiveness can be demonstrated;

(4) Advertising expenses other than those for advertising in the telephone directory yellow pages, for employee or contract labor recruitment, and for meeting any statutory or regulatory requirement;

(5) Business expenses not directly related to the provision of covered services. For example, expenses associated with the sale or purchase of a business or expenses associated with the sale or purchase of investments;

(6) Political contributions;

(7) Depreciation and amortization of unallowable costs, including amounts in excess of those resulting from the straight line depreciation method; capitalized lease expenses, less any maintenance expenses, in excess of the actual lease payment; and goodwill or any excess above the actual value of the physical assets at the time of purchase. Regarding the purchase of a business, the depreciable basis will be the lesser of the historical but not depreciated cost to the previous owner, or the purchase price of the assets. Any depreciation in excess of this amount is unallowable;

(8) Trade discounts and allowances of all types, including returns, allowances, and refunds, received on purchases of goods or services. These are reductions of costs to which they relate and thus, by reference, are unallowable;

STATE Texas
DATE REC'D 03-30-01
DATE APPV'D 11-13-01
DATE EFF 01-01-01
HCFA 179 TX-01-01

A

(9) Donated facilities, materials, supplies, and services including the values assigned to the services of unpaid workers and volunteers whether directly or indirectly related to covered services, except as permitted in 42 CFR Part 413;

(10) Dues to all types of political and social organizations, and to professional associations whose functions and purpose are not reasonably related to the development and operation of patient care facilities and programs, or the rendering of patient care services;

(11) Entertainment expenses except those incurred for entertainment provided to the staff of the RHC as an employee benefit. An example of entertainment expenses is lunch during the provision of continuing medical education on-site;

(12) Board of Director's fees including travel costs and provided meals for these directors;

(13) Fines and penalties for violations of regulations, statutes, and ordinances of all types;

(14) Fund raising and promotional expenses except as noted in paragraph (4) of this subsection;

(15) Interest expenses on loans pertaining to unallowable items, such as investments. Also the interest expense on that portion of interest paid which is reduced or offset by interest income;

(16) Insurance premiums pertaining to items of unallowable cost;

(17) Any accrued expenses that are not a legal obligation of the provider or are not clearly enumerated as to dollar amount;

(18) Mileage expense exceeding the current reimbursement rate set by the federal government for its employee travel;

(19) Cost for goods or services which are purchased from a related party and which exceed the original cost to the related party;

(20) Out-of-state travel expenses not related to the provision of covered services, except out-of-state travel expenses for training courses which increase the quality of medical care and/or the operating efficiency of the RHC;

STATE Texas
DATE REC'D 03-30-01
DATE APPV'D 11-13-01
DATE EFF 01-01-01
HCFA 179 TX-01-01

A

(21) Over-funding contributions to self-insurance funds which do not represent payments based on current liabilities;

(f) A visit is a face-to-face encounter between an RHC patient and a physician, physician assistant, advanced nurse practitioner, certified nurse-midwife, visiting nurse, or clinical nurse practitioner. Encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit, except where one of the following conditions exist:

(1) After the first encounter, the patient suffers illness or injury requiring additional diagnosis or treatment; or

(2) The RHC patient has a medical visit and an "other" health visit.

(g) A visit is a face-to-face encounter between an RHC patient and a physician, physician assistant, advanced nurse practitioner, certified nurse mid-wife, visiting nurse, or clinical nurse practitioner. An "other" health visit includes, but is not limited to, a face-to-face encounter between an RHC patient and a clinical social worker.

(h) Effective for each RHC's fiscal year which includes dates of services occurring on or after October 1, 2001, subsequent increases in an RHC's PPS per visit rate or the effective rate shall be the rate of change in the Medicare Economic Index (MEI) for Primary Care.

(i) The effective rate is the rate paid to the RHC for the current fiscal year. The effective rate equals the base rate plus the MEI for each of the RHC's fiscal years since the setting of its PPS rate. The effective rate shall be calculated at the start of each RHC's fiscal year and shall be applied prospectively for that fiscal year.

(j) An adjustment shall be made to the effective rate if change is due to a change in scope. An RHC or the commission may request an adjustment of the effective rate equal to one hundred percent (100%) of reasonable costs by the filing of a cost report and the necessary documentation to support a claim that the RHC has undergone a change in scope. A cost report, filed to request an adjustment in the effective rate, may be filed at any time during an RHC's fiscal year but no later than five (5) calendar months after the end of the RHC's fiscal year. All requests for adjustment in the RHC's effective rate must include at least 6 months of financial data. Any effective rate adjustment granted as a result of such a filing must be completed within sixty (60) days of receipt of a workable cost report and documentation

STATE Texas
DATE REC'D 03-30-01
DATE APP'D 11-13-01
DATE EFF 01-01-01
HCFA ID TX-01-01
A

supporting the RHC's claim that it has undergone a change in scope. Within sixty (60) days of submitting a workable cost report, HHSC or its designee shall make a determination regarding a new effective rate. The new effective rate shall become effective the first day of the month immediately following its determination. All subsequent increases shall be calculated using the adjusted effective rate.

(k) Any request to adjust an effective rate must be accompanied by documentation showing that the RHC has had a change in scope.

(l) A change in scope of services provided by an RHC includes the addition or deletion of a service or a change in the magnitude, intensity or character of services currently offered by an RHC or one of the RHC's sites. A change in scope includes:

(1) Increase in service intensity attributable to changes in the types of patients served, including but not limited to, HIV/AIDS, homeless, elderly, migrant, other chronic diseases or special populations;

(2) Any changes in services or provider mix provided by an RHC or one of its sites;

(3) Changes in operating costs which have occurred during the fiscal year and which are attributable to capital expenditures including new service facilities or regulatory compliance;

(4) Changes in operating costs attributable to changes in technology or medical practices at the center;

(5) Indirect medical education adjustments and a direct graduate medical education payment that reflects the costs of providing teaching services to interns and residents; or

(6) Any changes in scope approved by the Health Resources and Service Administration (HRSA).

(m) A workable cost report includes the following:

(1) For a hospital-based RHC, complete HCFA Form 2552 and HCFA Form 339 with Certification by an Officer or Administrator including:

(A) M-1 (Analysis of provider-based RHC costs).

(B) M-2 (Allocation of overhead to RHC services).

STATE Texas
DATE REC'D 03-30-01
DATE APPV'D 11-13-01
DATE EFF 01-01-01
HCFA 179 TX-01-01

A